immunizing dogs against trypsin intoxication and against transplantation of pancreas tissue otherwise fatal.

Operation in these cases is often accompanied by uncontrollable hemorrhages. In one of Robson's cases the patient died from a continuous oozing of the surgical wound which resisted all known means of hemostasis. He has found this to be true, especially in those cases accompanied by jaundice, and far more dangerous than in the jaundice of biliary disease alone. In such cases he recommends the administration of calcium chloride in 30 to 60 gr. doses three times a day, for 24 to 48 hours before operation and by enema in 60 gr. doses three times a day for 48 hours after operation. By this precaution hemorrhage has been avoided.

CLINICAL NOTE, A PRACTICAL POINT IN INSTRUMENTAL DIAGNOSIS.

C. M. COOPER, M. B.

It has long been widely known that the eyelets of a stomach pump may during gastric lavage become occluded by the gastric mucous membrane, and if the pump be then withdrawn a piece of membrane may be torn from its moorings, and brought away with the tube. The suction into the tube eyelet often occurs suddenly, and is commonly evidenced by a peculiar jerk which may be felt throughout the entire tube. To avert any trauma, we pour a little water into the raised funnel; this forces the mucous membrane away from the tube opening, and we withdraw the tube past the cardia while the water is still flowing into the stomach.

It is not so well known that analogous mishaps may occur during the use of other instruments of diagnosis, e. g., the ureteral catheter and the simoidoscope.

Perhaps the recital of an actual occurrence may best convey one's meaning. I lately saw in consultation a lady afflicted with what I believed was, and which, indeed, at operation proved to be, a large malignant tumor arising from a left floating kidney. I advised and was then asked to make a preoperative determination of the right kidney function. The ureteral catheter was introduced painlessly without the use of an anesthetic. The cystoscope was withdrawn clean. Urine dropped intermittently from the catheter. I watched the procedure for half an hour and then left, leaving instructions with a competent person to withdraw the catheter after another half hour. The report later given me was as follows: Urine had continued intermittently to drop into the receptacle for ten minutes, then had ceased, pain being complained of along the course of the ureter. The catheter was left in position for another twenty minutes, during which time no urine flowed from it; it was then withdrawn. Two drops of "thick" blood fell from the catheter eyelet and the patient passed blood in the urine for the next six hours.

An almost identical episode happened to me a week later. This time, however, the patient passed blood for twelve hours. I believe that during the passage through the catheter of the drop of urine immediately preceding the lull, a piece of ureteral mucous membrane had been sucked or forced into the catheter eyelet, and then either ureteral contractions or the withdrawal of the catheter had caused an abrasion, from which the blood came. Common sense would seem to suggest that when such happens a little sterile water should be injected with a hypodermic syringe into the catheter, thus forcing away from the eyelet the mucous membrane, and that the catheter be withdrawn during the injection.

In proctoscopic work the mucous membrane of the lower part of the sigmoid or of the upper part of the rectum can be frequently seen to be driven or sucked into the mouth of the instrument. If the tube be then withdrawn there is a tendency to the production of a partial prolapse, or to a dry cupping of the mucous membrane. Removing the cap and thus insuring a continuity between the external air and the column of air in the rectum does not always lead to a replacement of the rectal mucous membrane any more than does continuity between the external air and the columns of air within the stomach tube or ureteral catheter prevent injury to the mucous membrane of those structures. But if air be gently pumped in, the tissues are lifted away from the tube and the instrument can be drawn back into the lower rectum, the cap removed, then the instrument withdrawn in safety. I may add that I have learned through experience the advisability of making such proctoscopic examinations before allowing the presence of occult blood in the stools to influence a doubtful diagnosis, and then take the opportunity to collect some fecal matter in the inner end of the tube, as it lies in the vicinity of the rectal-sigmoid junction, thus avoiding contamination from little hemorrhagic spots in the lower rectum, from hemorrhoids or from anal canal excoriations.

DIAGNOSIS AND TREATMENT OF ECTOPIC PREGNANCY.*

By GEO. B. SOMERS, M. D.

One of the most interesting conditions met with in the diseases of women is ectopic pregnancy. It fixes the attention because of its insidious nature, the obscurity of its symptoms, and because it often ends fatally even before the true situation is realized.

Though the condition is now well understood, and though an enormous number of articles have been written about it, nevertheless its serious nature and the frequency with which it is overlooked, are sufficient apologies for resurrecting the subject. In order to guard against adding to the long list of undiagnosed cases of ectopic pregnancy, many of which have slipped away to death when they might have been saved, it is necessary to keep constantly in mind a vivid mental picture of the condition and make sure that it is eliminated before attempting to diagnose any case of pelvic disease.

Frequency — An important factor in diag-

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